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ABSTRACT

This paper describes the methodology used in a study assessing the health needs of the Asian population, specifically the Chinese, Cambodian, and Vietnamese populations, in Santa Clara County, California. The study by the Santa Clara County Health Department is part of a wide-ranging needs assessment project primarily intended to guide administrative decision-making in the provision of services to the county's residents. Secondarily, the project is intended to add to the available general knowledge base about mental health. The report is divided into the following sections: (1) sample design; (2) survey instrument; (3) selection and training of interviewers; (4) editing, verification, coding, and data processing; (5) publicity and interviewer identification and verification; (6) study schedule; (7) costs; and (8) resultant sample. Appended to the report are the project timetable, project costs, a variable list for open-ended nonmedical questions, the coding method for open-ended nonmedical questions, age/sex graphs for the sample, and project staff resumes. (CMG)

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ED236268

AUGUST, 1983

SANTA CLARA COUNTY ASIAN HEALTH SURVEY:

METHODOLOGY

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UD 023116

SANTA CLARA COUNTY HEALTH DEPARTMENT

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SANTA CLARA COUNTY HEALTH DEPARTMENT

ASIAN HEALTH ASSESSMENT PROJECT

SOLENG TOM M.D., CONNIE YOUNG YU,

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JULY 30, 1983

I. INTRODUCTION

The Santa Clara Mental Health Bureau, a bureau of the Health Department, initiated a wide-ranging needs assessment project in 1979, using epidemiologic techniques already well developed by a variety of university-based investigators. To date the project has completed a variety of rates under treatment studies, social indicator studies, and community surveys. These separate studies have also been interrelated. The project is conceived of as an administrative epidemiologic one, in that the results are primarily intended to guide administrative decision making in the provision of services to the 1.3 million people living in the county. Secondarily, it is intended to add to the available general knowledge base about mental health needs. Because some portions of the county population represent groups of people about which little or nothing is known regarding absolute or relative psychological distress and dysfunction, some significant parts of the studies do have general interest.

The immediate antecedent of the present project was a community survey of the general population, and a concurrent

survey targeted to the Mexican-origin population of the county, done in April-July, 1980. The findings of both surveys have been described in detail in reports available from the mental health bureau, and will only be described here to the extent needed to understand the present survey.

The 1980 surveys were based on the Florida Health Survey developed by George Warheit Ph.D, who was consultant on the project. Random digit dialing was the sampling method used and all interviews were by telephone. The general population sample consisted of 842 interviews, and the Mexican-origin sample of 503 interviews. It was recognized at the time that the general sample would almost certainly contain an unrepresentative sample of the Asian population of the county, which is a minority population of increasing size, due in part to the influx of Indochinese refugees. The 1980 census indicates 6% of the county population is Asian. The lack of representation was the inevitable result of using monolingual English-speaking interviewers for the general sample. Bilingual, bicultural interviewers and other project staff were employed for the Mexican-origin survey, and one of the most powerful variables for distinguishing a group high in psychological distress was the respondent's choice to be interviewed in English or in Spanish. The Spanish-preference respondents as a group exhibited very elevated scores on measures of depression, anxiety, and psychosocial dysfunction when compared to the group preferring English or to the general population. The results of the general survey indicated the English-speaking Asian respondents as a group

had a lower level of distress than the White or other ethnic population groups, lending support to the likelihood of the sample not being representative of the whole Asian population.

At the time, the need for the present study was evident, but the marginal nature of the funding of these surveys, as well as what appeared to be formidable methodological and practical operational problems caused the bureau to delay initiating the project until the spring of 1983.

A word about the funding constraints of these surveys -- no specific outside grant or other funding dedicated to the project has been available. Because of the lack of specific funding, a special funding strategy has been necessary: first, maximum use has been made of qualified individuals already a part of the bureau's staff by temporarily deploying them full or part time to the project; second, revenues for new costs of the projects have been drawn from year-end savings in the services budget of the bureau. Because the total budget of the bureau is about 25 million dollars, even with close budget management, some funds (usually less than 1%) are unspent at year end. The size of these funds that will not be needed for their intended purpose begins to be evident in January of each year, but this is not firm enough until about April to reallocate. Since the funds must be expended prior to the end of the fiscal year the surveys have been carried out in April through June.

Staffing for the present survey was developed as indicated by using appropriate bureau staff, supplemented by new staff as needed. The core staff for the survey, and

their roles consisted of the following:

Kenneth Meinhardt M.D., Project Director. Role: Responsible for the overall project design, and general implementation. Also responsible for design of the computer-based data file, for correction of keypunch and other errors in the computer data, for writing computer programs to analyse the data, and presentation of tables.

Soleng Tom M.D., Project Manager. Role: Responsible for developing and managing the implementation of the general design of the survey, including sampling design, acquisition of translations, selection and supervision of all other project staff. Responsible for developing the timetable for interviews, and for general supervision of the interview process.

Connie Young Yu, Operations Manager. Role: Responsible for day to day operation of the project; monitor all interviewer's work; verification of sampling procedures and techniques; maintainance of daily activity recording of the monitoring and collation of all data; liaison with key-punch and computer support services; interface with bureau fiscal staff; liaison with Asian community leaders and organizations; responsible for publicity and public relations; coordinate office management; supervise and consult with team leaders.

Philip Tse MPH, Project Coordinator. Role: Responsible for coordinating interviewers and the overall data collection phase, including monitoring of budget, recruiting, training, and supervising the daily activities of interviewers and editing of the survey instruments; served as team leader for

the Chinese-speaking interviewers and worked closely with project staff in developing the Post Traumatic Inventories Questionnaires (PTIQ).

II. DESIGN OF THE SAMPLE

The goal was to get a representative sample of the Asian population of the county 18 years of age or older. Because of fund and time limitations, not all Asian groups could be surveyed. It was important to include as wide a socio-economic range as possible, and as wide a range of tenure in the United States as possible, so that both multi-generation residents of the U.S. and recent immigrants would be sampled. Because the least is known about both the general and mental health needs of Indochinese refugees, it was decided to target those groups for more extensive sampling than other groups. Language and dialect appeared to pose very great problems, and practical limitations of number of languages that could be managed in a single survey dictated choosing a limited number of language groups.

Two Asian population groups were initially chosen for the study after careful consideration. The Chinese population was chosen for a variety of reasons: one, the 1980 survey contained a small number of Chinese respondents and the results of the English survey conducted by White monolingual interviewers could be compared to the results obtained by bilingual, bicultural Chinese interviewers in the present survey; second, the Chinese population of the county includes a very broad range of socio-economic levels and degrees of

acculturation, useful for linking the results of the 1980 surveys to the Asian survey. Immigrants, refugees and those who were born in the United States are all present in the Chinese population of the county; and third, some portion of the Indochinese refugees, although coming from Vietnam, Cambodia, and Laos, in fact speak Chinese and are of Chinese ancestry. By including the Chinese language in the survey, these refugees could be sampled.

The second group initially chosen was the Cambodian population. This was based on the accident of having better access to this group than to some of the others, rather than a methodological reason. They were, it was felt, as likely to be representative of the Indochinese refugee population as any other single choice would be, and were known to contain individuals at the extreme low end of the socio-economic spectrum. In addition, the Cambodian population had settled in fairly discrete, identifiable areas of the county, making access for face to face interviewing possible.

Census tracts were produced within the community that had the highest concentration of Cambodian residents as suggested by Cambodian community leaders. Within each census tract specific city blocks were chosen that would likely contain the largest concentration of Cambodian residents. Each sampling day the Cambodian team leader would arbitrarily designate a starting intersection/block and individual interviewers would then make contact with every third address from that original starting point. When a potential Cambodian respondent contact was made, any individual male or female over the age of 18 who was at home at that time and

was willing to be interviewed, was chosen. In the case of more than one person being willing to be interviewed at a given address, because of cultural norms, the head of the household was given the first choice to be interviewed. If more than one family lived at the same address, the first contact person's family was used as the family of residence at that address. Systematic logs of each day's work and of addresses contacted were kept. There was a zero refusal rate, quite unusual in such surveys, and calls for a word of explaination. The zero refusal rate could be attributed to several factors. These included:

1. The Cambodian team leader was in fact president of the Cambodian New Life Association of Santa Clara County. This status and also his original status in Cambodia probably aided the willingness of all of the respondents.
2. Other members of the Cambodian team also hold high indigenous positions of leadership and authority in the Cambodian community.
3. Respondents were offered three dollars as a token of appreciation for accepting the interview.
4. The Cambodian community is a very closely knit group and is geographically centralized within the county. Prior news releases and community education were of a high profile nature. The fact that this project was important to the community was strongly conveyed, adding to the potential of high compliance.
5. Because of the nature and caliber of the interviewers there seemed to be a high level of trust by the Combodian community regarding this project.

As the project started to take shape, a Vietnamese translation of the survey instrument was made available by a Vietnamese psychiatrist on the staff of the bureau, Dr. Oanh Vu. Because of this fortunate circumstance, a decision was made to extend the survey to the Vietnamese population as well.

Sampling decisions were complex and involved many compromises because of the nature, the size and the location of the three minority populations. In the 1990 surveys it had been feasable to use random digit dialing telephone sampling even for the Mexican-origin population by concentrating phone calls for that population in prefix areas known to have concentrations of Hispanic residents. Even so, very large numbers of calls were required before a Mexican-origin potential respondent was reached. Random digit dialing was clearly impossible for groups constituting only 6% of the total population.

In addition, the Chinese population is largely integrated into the county, and there is no equivalent of the Chinatown of San Francisco in Santa Clara County. However we found a number of recent immigrants and refugees of Chinese ethnicity clustered in the downtown San Jose area. These people were sampled by the door to door method, while the general Chinese population was sampled by phone.

The Asian staff of the project suggested the telephone sampling alternative finally used. They noted that Asian names are rather characteristic for each Asian ethnic group, and in most cases differentiable from non-Asian names. The aim then became to generate a universe of all Chinese,

Cambodian, and Vietnamese that had listed phones in Santa Clara County. First, an exhaustive list of all Chinese, Vietnamese, and Cambodian last names was generated. Bilingual bicultural staff made the initial list and then cross referenced these surname lists with as many Asian community organization membership lists as could be obtained. Use of all possible English spellings of these last names was attempted. We reasoned that if a non-Asian person was called, they could be easily excluded from the study, and that would be better than omitting names such as "Lee" and "Young" that could be Asian or non-Asian.

After the three dictionaries of ethnic names were completed, all Santa Clara County phone directories were scanned for each ethnic group, and all names in the directories which appeared on the appropriate list were marked and extracted from the phone books. All individuals living outside the county were omitted. Then, starting at a randomly selected place, every tenth marked name was selected for inclusion in the lists of telephone numbers to be called. All directories were sampled. Each of the three list was drawn separately from separate sets of phone directories, since there was some overlap of names between the Chinese, Cambodian, and Vietnamese. In this way all identifiable members of each ethnic group had the chance of being included in the sample, at the expense of also including some members of other groups -- a better situation than excluding some names from the sample.

As indicated earlier, the wide distribution of the general Chinese population made this approach the only

feasable sampling technique, given the time and cost limits of the project. Chinese with non-Asian names through marriage, etc. were necessarily not reached by this method. Chinese without telephones were also omitted. On this point, however, we were told by the telephone company in 1980 that only 1% of county households were without a phone. Perhaps a larger omission is that of households with unlisted telephone numbers. The effect on the representativeness of the sample cannot be evaluated with any degree of certainty.

The potential for use of face-to-face interviews was evaluated for all three Asian groups. Because it was clearly impossible to use door-to-door methods unless high-density Asian areas could be found, 1980 Census data at the census tract level was reviewed. Those census tracts with the highest percentage of Asian population were chosen for further study. Using the personal knowledge of Asian project staff, and of Asians in the community, an attempt was made to define city blocks within the census tracts which had a high concentration of Asian population. With the exception of the Cambodian, and a very small part of the Vietnamese and Chinese refugee population, no large clusterings of Asians could be identified. However, some city blocks were chosen for each of the three ethnic groups for a trial of face to face interviewing, since early in the project there was some serious doubt that Asians would respond well to telephone interviews. For these trials interviewers chose one corner of a selected block at random, and then knocked on the door of every third, or in some cases, every fourth residential street address. The trials in the Chinese and Vietnamese

populations clearly indicated the amount of time and the cost per completed interview was prohibitively high. Also with the Chinese, because of the numerous dialects, to be efficient, interviewers fluent in all Chinese dialects needed to be available once a positive contact was made. This was a virtually impossible requirement in the field, given the time and budget limitations. Near the end of the sampling period the geographically clustered Chinese refugee population was identified, and face to face interviews conducted. The Cambodian population proved more available to door to door sampling techinques since they had located close to other Cambodians, and this formed high density areas which were easily definable.

In the 1980 study, in order to assure the appropriate age and sex representation of the population of the county, a stratified sample by sex and three age groups (18-34, 35-54, and 55+ years) was used. The Asian sample was also followed as the interviewing was taking place to monitor the adequacy of the sample in each of the six cells. However, it proved impossible to obtain Census data on age-sex distribution in the three specific ethnic groups prior to the completion of the survey, so the degree to which the sample was representative could not be determined, while data gathering was taking place.

III. THE SURVEY INSTRUMENT

The survey instrument used for this survey was essentially the same one used for the 1980 surveys, which was

in turn based on the Florida Health Questionnaire developed by George Warheit Ph.D.

For each of the three languages, Chinese, Vietnamese, and Cambodian a bilingual, bicultural person was asked to translate the original document from English into their native language. After this was done, additional bilingual, bicultural translators were given the translations and were asked to translate the questionnaire back into English. These 3 back translators were never shown an English version of the questionnaire. Each back translation was then scrutinized by the project staff, question by question, to determine how faithful the back translations were to the original. Asian staff and the project director, who had been project co-director for the 1980 surveys, worked together closely to improve the translations, so that the original intent of questions would be accurately preserved in all three languages.

Because there are several dialects of Chinese, translators were used who were fluent in all major Chinese dialects to review the translated questionnaires so that the Chinese instrument would be as clear and accurate as possible in all major dialects.

The Vietnamese original translation was done by a "Northern" Vietnamese and was subsequently re-evaluated by a "Southern" Vietnamese speaking person. The aim again was to minimize any language, dialect or idiomatic geographical variation. The Cambodian instrument was given similar treatment.

Two additional procedures were used in reaching a final

version. First, a preliminary trial was done, using volunteer respondents. These were focused on issues of timing, clarity of questions, cultural sensitivity, and difficulty of using the instruments. Translation problems and ambiguous questions were looked at in all of these trials, and they were repeated with each new draft until the project staff felt all identifiable problems had been resolved.

The second procedure for each language was performed during the training of interviewers. Each ethnic language team went over the translations question by question with the project staff, and further corrections and polishing of the final documents took place. In the training process interviewers administered the questionnaire to one another, and again project staff sitting in on these sessions examined questions needing further clarification.

In translating the questionnaire one of the paramount considerations was to make the documents culturally and socially acceptable to the targeted populations. Where literal translation of terms was not possible, bilingual bicultural people were asked to consult with us. Several questions were rewritten in this way to be more culturally acceptable, relevant, and faithful to the intent of the original English document.

Some of the questions in the original which were specific to ethnicity and language were modified to fit the Asian population being surveyed. But the core of the instrument which consists of 5 standard scales measuring various aspects of psychological distress and dysfunction was

carefully preserved, and received the most attention to accuracy of translation.

This survey presented an opportunity not likely to come again to ask questions specific to the experience of the Southeast Asian immigrant population. We asked members of the ethnic professional community and general community groups if there were specific areas or questions of interest we could include in the survey. In appendix A are the questions generated specifically for the refugee population. These questions had been used before in interviewing war survivors. These were included in the questionnaire to give a better understanding of the health information already therein.

With these additions, the average time to administer the questionnaire, which consisted of 126 questions (see attachment B), was thirty-five minutes for all three languages.

The translated Santa Clara County Health Survey instrument includes items in the following major areas:

1. Respondent's current health status and health services received for current health problems (questions 1-4).
2. Respondent's utilization of health services durng the last 12 months (questions 5-14).
3. The current health status of people living in the same household with respondent (question 21).
4. The utilization of Public Health Department services by respondent's household members (questions 22,23).
5. Information about children's immunizations (questions 19.20).

6. Existence of support system structure and respondent's satisfaction with the support system structure (questions 24-31).

7. Demographic information of the respondent, like age, sex, income, occupation, employment status, marital status, etc. (questions 14-18, 78-92, 94-107).

8. Health and mental health scales:

   a. Health Opinion scale (HOS, 20 items)

   b. Depression scale (DEP, 17 items)

   c. Psychosocial Dysfunction scale (PDS, 11 items)

   d. Anxiety scale (ANX, 12 items)

   e. Cognitive Impairment scale (COG, 4 items)

9. Existence of negative stressors in respondent's life during the last 12 months (questions 108,109)

10. Post Traumatic Inventories Questionnaire for Southeast Asian refugees. This set of questions was developed in the light of information in: "psychiatric Consultation in a Vietnamese Refugee Camp" by Rahe R H, Looney J G, Ward H W, et al, published in the American Journal of Psychiatry 135:pp 185 - 190, 1978.

IV. SELECTION AND TRAINING OF INTERVIEWERS

Announcements for bilingual bicultural interviewers were sent to all Asian community groups, government agencies, Asian media, local schools and selected individuals in the San Francisco bay area for distribution. As candidates replied interviews were arranged with two project staff members. Selection criteria included being bilingual and

bicultural, and fluent in both the spoken and written language, and in English. A wide cross section of age, sex, and background experience was sought for the interviewer group. Interviewers were also selected on their fluency, the number of dialects spoken, their energy, interpersonal and communication skills, understanding of our methodology and their cultural sensitivity and understanding. To facilitate face to face interviews qualities from each cultural perspective were considered that would give the highest probability of being accepted into homes.

The final group of interviewers was equally balanced in the number of men and women, and ranged in age from 21 to 77. Some interviewers were physicians, college students, retirees, and teachers. After all interviewers were hired, a "team leader" for each ethnic group was appointed to help coordinate the members of each group as the project got underway. Training consisted of two full intensive days of training plus hours of individual monitoring and "on the job" training. Collectively and in their ethnic teams each document was gone over both in the language and in English many times until the project managers were confident that each interviewer understood the meaning of each question and could fluently convey it in the appropriate language. Interviewers then practiced administering the questionaires amongst themselves and were monitored by project staff. They were then monitored individually on the first servies of actual sampling calls and regularly thereafter. There was special emphasis on working on the initial contact and on presentation of the interviewers in the most culturally

relevant and appropriate manner. We also encouraged interaction among interviewers to build a cohesive team spirit. A considerable amount of time was spent explaining the project, the protocols to use, sampling techniques, and the necessity for carrying out the project in a manner free of error and bias.

V. EDITING, VERIFICATION, CODING AND DATA PROCESSING

A. Editing and Verification of Questionnaires

Upon receipt of each returned questionnaire, it was given an appropriate respondent identification number. The project staff or the team leader edited each questionnaire for clarity and completeness. Daily logs were kept for record and checked to make sure the sampling methods conformed to the protocol. At least 5 percent of the interviews were verified, selecting at random. Verification was done by calling or revisiting respondents, and was done by the team leader or core project staff. All of the cases selected passed this verification test.Call backs to refusals and on the spot monitoring of telephone interviews by supervisory project staff was also used as a means of verifying that interviewers were following the sampling and interviewing protocol.

All open-ended questions that were answered in an Asian language were translated into English for future coding and error correction that might be done by English-speaking staff. Medical terminology was coded by medical doctors, using the International Classification of Disease

nomenclature (ICD-9-CM).

B. Coding, Data Processing, Keypunching

1. Precoded Items

Questionnaires were numbered, to differentiate the samples by questionnaire number in the following way:

IDENTIFICATION NUMBERS		
From	To	NATIONALITY
7000	7377	CAMBODIAN
8000	8565	VIETNAMESE
8700	8789	CHINESE(English speaking only)
9000	9557	CHINESE SPEAKING ONLY
9600	9691	CHINESE SPEAKING(prefer English)

The precoded items were punched on data cards 1, 2, and 3. The variable list for these cards is on the right margin of the questionnaire.

2. Open-ended non-medical questions

Before questionnaires were sent to keypunching responses to all of the open-ended questions were translated into English for future reference and also coded onto an additional data entry document, using coding conventions developed in the 1980 survey. All coding was done by selected interviewer staff. This data was then keypunched to card 4, using the variable list in the Appendix.

3. Open ended medical coding

Questionnaire items 2b, 3b, and 13b dealt with the respondent's present health problems, the medical problems treated during the last 12 months, and illnesses or symptoms treated with prescribed

medicine during the last 12 months. The Chinese sample was coded by the Project Manager, and the Vietnamese sample by a Vietnamese physician, using the International Classification of Disease (ICD-9-CM).

Medical coding was punched on the 5th data card. The variable list for this is in the Appendix.

4. Refugee Questions

The Post Traumatic Inventories Questionnaire (PTIQ), completed by all war refugees, was coded onto card 6, as indicated in the right margin of the questionnaire. The PTIQ was drawn in part from a questionnaire used to measure war experience by Rahe, et al

(ref. Rahe R H, Looney J G, Ward H W, et al: Psychiatric Consultation in a Vietnamese Refugee Camp. Am J. Psychiatry 135: 185-190,1978)

VI. PUBLICITY, INTERVIEWER IDENTIFICATION AND VERIFICATION

Prior to initiation of the actual interviews, press releases were made to all Asian media and other public media, both printed and electronic. Also all known Asian community groups and local government bodies were notified, and their support gained.

All interviewers were issued photo identification badges and letters of introduction. Police departments were notified in municipalities selected for sampling. A public complaint/verification phone number was also made available

during interviewing hours.

VII. STUDY SCHEDULE

The timetable for the project is in the appendix. Planning took place in March,1983, translations of the questionnaire in March and April, and publicity in May and June. Hiring and training of interviewers occurred in April, and interviews in May and June.

VIII. COSTS

The costs directly associated with the project are detailed in the appendix. Because costs of three of the four primary project staff were absorbed in the ongoing budget of the Mental Health Bureau, as was part of the printing, paper, telephone, keypunching, and computer time, the actual cost of the project was somewhat higher than the new costs. The grand total of new project costs was $28,161, or $16.72 per completed interview.

IX. RESULTANT SAMPLE

The questionnaires completed, broken down by ethnicity and language preference:

	NUMBER OF INTERVIEWS
CANBODIAN	378
VIETNAMESE	566
CHINESE(SPEAK ENGLISH ONLY)	90
CHINESE(SPEAK CHINESE ONLY)	558
CHINESE(BILINGUAL, PREFER ENGLISH)	92
TOTAL SAMPLE SIZE	1684

In the sample are 72 Cambodian Chinese and 77 Vietnamese Chinese.

The sample, broken down by interviewing method:

	PHONE INTERVIEWS	FACE-TO-FACE
CHINESE	583	157
VIENAMESE	515	51
CAMBODIAN	9	369
TOTAL	1107	577

The sample, broken by age group and sex, appears in bar graphs in the appendix, and in the following table:

		MALE	FEMALE
CAMBODIAN	18-34	101	91
	35-54	70	60
	OVER 54	20	36
VIETNAMESE	18-34	166	141
	35-54	115	81
	OVER 54	33	23
CHINESE (MONOLINGUAL CHINESE)	18-34	120	167
	35-54	65	89
	OVER 54	56	61
CHINESE (MONOLINGUAL ENGLISH)	18-34	30	20
	35-54	16	15
	OVER 54	3	6
CHINESE (BILINGUAL, PREFER ENG.)	18-34	20	21
	35-54	19	18
	OVER 54	10	4

The refusal rate was very low for all samples, as this table indicates:

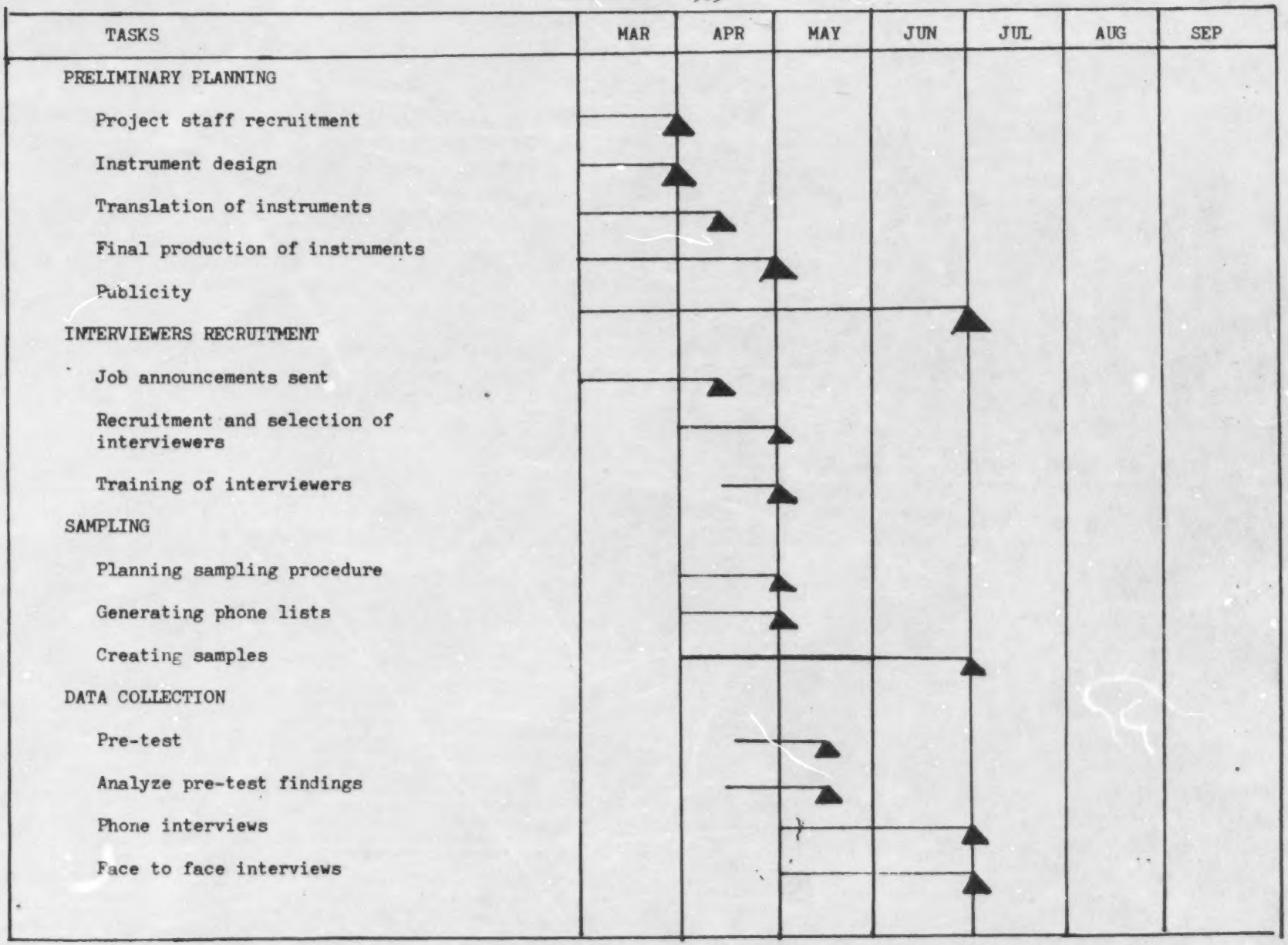
ETHNIC GROUP	SAMPLE SIZE	REFUSALS	REFUSAL RATE
CAMBODIAN	378	0	0%
VIETNAMESE	566	22	3.9%
CHINESE	740	72	9.7%
TOTAL SAMPLE	1684	94	5.6%

The overall refusal rate was 5.6 percent.

APPENDICES

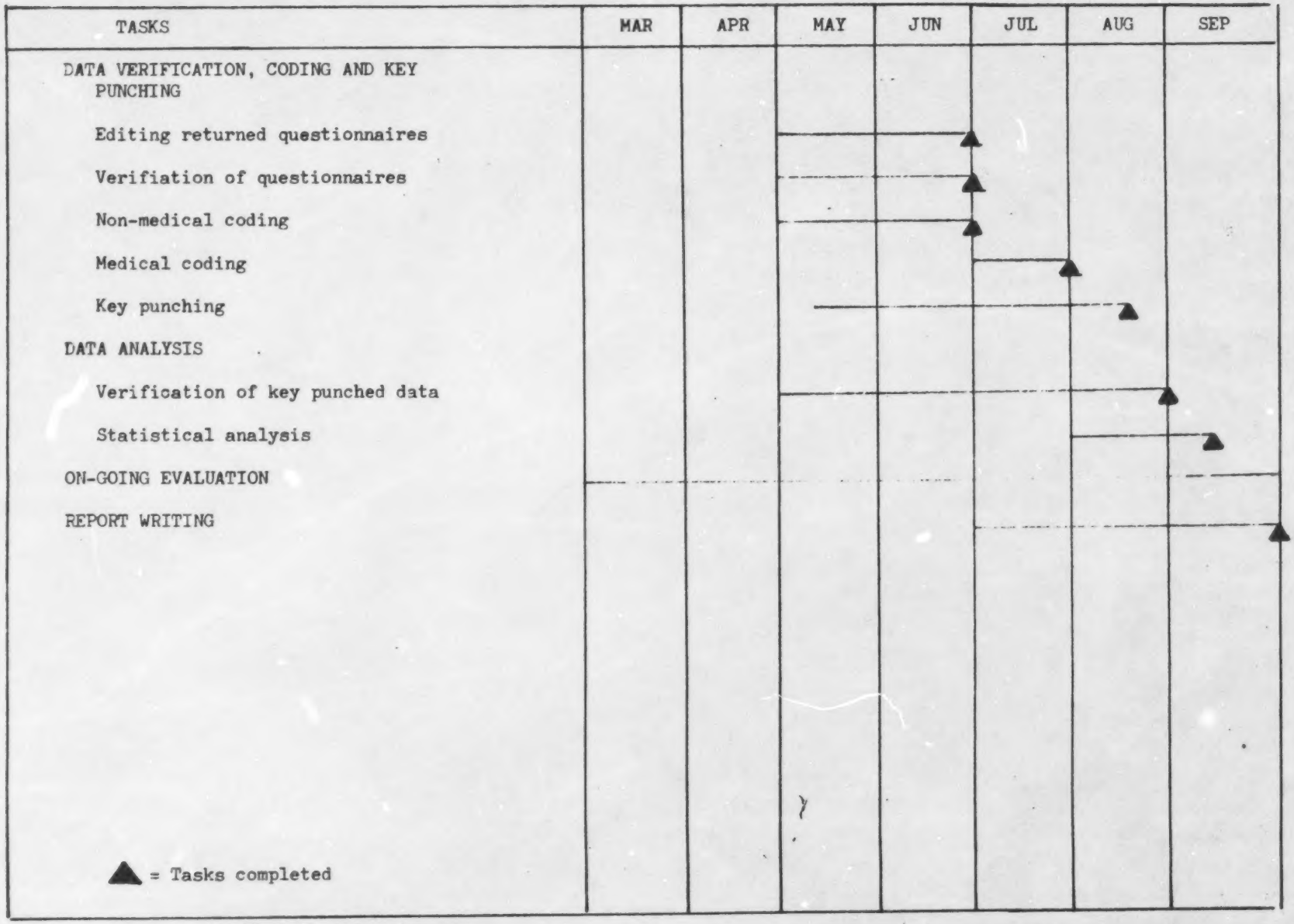
1. Project timetable.
2. Project costs
3. Variable list for open-ended non-medical questions.
4. Coding method for open-ended medicalquestions.
5. Age/sex bar graphs for the samples.
6. Project staff resumes.

SANTA CLARA COUNTY
ASIAN HEALTH ASSESSMENT PROJECT
TIMETABLE - 1983



APPENDIX 1 PAGE 1

SANTA CLARA COUNTY
ASIAN HEALTH ASSESSMENT PROJECT
TIMETABLE - 1983



APPENDIX 1 PAGE 2

APPENDIX 2

SANTA CLARA COUNTY HEALTH DEPARTMENT
ASIAN HEALTH ASSESSMENT PROJECT
BUDGET SCHEDULE

	Projected	Actual
I. PERSONNEL		
A. Operation Manager salary	$6,000	$6,000
B. Heatlh Assessment Interviewers salary:		
1. Chinese interviewers	$6,000	$7,302.25
2. Vietnamese interviewers	$6,000	$6,303.00
3. Cambodian interviewers	$6,000	$4,943.50
C. Paid Respondents	$1,800	$1,722.00
Personnel Expenses Total	$25,800	$26,270.25
II. NON-PERSONNEL		
A. Travel reimbursements	$870	$1,060.24
B. Other costs		
1. Typing translation on special typewriters into:		
a. Chinese	$400.00	$110.00
b. Vietnamese	$400.00	$320.00
c. Cambodian	$200.00	$319.00
2. Photo Identification Badges	$200.00	0
3. Misc. Expenses	$200.00	$ 81.50
Non-Personnel Expenses Total	$2,470.00	$1,890.74
Grand Total For Project	$28,270.00	$28,160.99

June 30, 1983

SANTA CLARA COUNTY HEALTH STUDY

ASIAN STUDY

Respondent ID# ____ ____ ____ ____ | Card 4 Column 1-4

Card #4 | 5

Census Tract ____ ____ ____ ____ ____ ____ | 7 - 12

DATA FROM:

Page 2

Question 12 What agency was it? _____

1. Physical health 2. Mental Health 3. Alcoholism | 13
4. Drug Abuse 5. Vocational Rehabilitation 6. Family Planning
7. Welfare 8. Unclear

Page 10

Question 83 In what country were you born?

Other _____

1. Other part of Asia or India | 15
2. Other part of North Amnerica
3. South or Central America
4. Pacific Islands
5. Africa 6. Europe or Russia 7. Australia or New Zealand
8. Elsewhere

Question 85 In what country was your spouse born?

Other _____

1. Other part of Asia or India | 16
2. Other part of North America
3. South or Central America
4. Pacific Islands
5. Africa 6. Europe or Russia 7. Australia or New Zealand
8. Elsewhere

Question 86 In what country was your mother born?

Other _____

1. Other part of Asia or India | 17
2. Other part of North America
3. South or Central America
4. Pacific Islands
5. Africa 6. Europe or Russia 7. Australia or New Zealand
8. Elsewhere

Page 11

Question 87 In what country was your father born?

Other _____

1. Other part of Asia or India | 18
2. Other part of North America
3. South or Central America
4. Pacific Islands
5. Africa 6. Europe or Russia 7. Australia or New Zealand
8. Elsewhere

APPENDIX 3

Question 89 Which of the following best describes you?
Other _____
1. White 2. Black 3. Japanese 4. Chinese 5. Filipino 19 - 20
6. Korean 7. Vietnamese 8. American Indian 9. Asian Indian
10. Hawaiian 11. Guamanian 12. Samoan 13. Eskimo 14. Aleut
15. Other 16. Cambodian 17. Laotian 18. Thai

Code: 0 21

Question 92 What language?
Other _____
1. Chinese 2. Vietnamese 3. Cambodian 4. Laotian 5. Tagalog 22
6. French 7. Spanish 8. Portuguese 9. Thai

Page 13
Question 98 Are you employed less than full time because of one of the following reasons?
Other _____
1. Retired 2. Seasonal worker 3. Fired or laid off 4. Going to 23 - 24
School 5. Children at home 6. Pregnancy 7. Unable to find work
8. Disabled 9. Other 10. Housewife 11. Quit, Resigned

Question 103A What do you consider your main job or occupation: |__|__|__| 25 - 27

Question 103C What kind of business or industry do you work in? |__|__|__| 28 - 30

Page 14
Question 106 A. Income Questions
1. income figure present 31
2. respondent does not know
3. refusal

B. Taxes
1. before taxes 32
2. after taxes
3. not indicated
7. does not know

C. Unit of time
1. Year 2. Month 3. Week 33
4. Several months 5. Several Weeks
7. Does not know

D. If months or weeks, the number of months or weeks |__|__| 34 - 35

E. Income if indicated in dollars |__|__|__|__|__|__| 36 - 41

F. Income if indicated in a group Group # |__|__| 42 - 43

Page 15
Comments (TRANSLATE INTO ENGLISH)_____

_____

_____

_____

_____

Code # |__|__| 46 - 47

Question 108 During the past 12 months has anything happened which upset you greatly for more than a few days? 48

1. yes
2. no
7. don't know
8. refusal

Question 109 If yes, what were they? (TRANSLATE INTO ENGLISH)

_____

_____

_____

_____

(Use coding sheet)

First stress code |__|__| 58 - 59
Second stress code |__|__| 60 - 61
Third stress code |__|__| 62 - 63
Fourth stress code |__|__| 64 - 65
Fifth stress code |__|__| 66 - 67
Sixth stress code |__|__| 68 - 69

KM:th
6/6/83 Rev. 6/13/83
d/50

CODES FOR STRESS QUESTION

Page 15, Question 109

PROBLEM OR SOURCE OF STRESS	Self	Parent	Spouse	Sibling	Child	Grandchild	Grandparent	Other kin	Friend	Acquaintance
Death of:	01	02	03	04	05	06	07	08	09	10
Accident/physical health of:	11	12	13	14	15	16	17	18	19	20
Mental health problem of:	21	22	23	24	25	26	27	28	29	30
Encarceration of:	31	32	33	34	35	36	37	38	39	40
Police contact of:	41	42	43	44	45	46	47	48	49	50
School problems of:	51	52	53	54	55	56	57	58	59	60
Other problems of:	61	62	63	64	65	66	67	68	69	70

OTHER SELF OR FAMILY PROBLEMS OVER:

71 Immigration status

72 Housing change

73 Immigration recency

74 Migration recency

75 Welfare dependency

76 Finances

77 English

78 Unemployment/Underemployment, temporary

79 Unemployment/Underemployment, chronic

80 Relations with employer

81 Relations with fellow workers

82 Housing

83 Neighborhood

84 City or Town

85 County

86 California

87 USA

88 Retirement

89 Major business adjustments

90 Major change in financial status (non-retirement)

91 Religion

92 Other

93 Breakup with Boy/Girlfriend

94 Separation/Divorce/marital problems

95 Other specific family problem

96 Problem with son/daughter or separation from son/daughter

97 Refusal

98 DK

99 [Illegal Skip]

APPENDIX 4 PAGE 1

CODING METHOD FOR OPEN ENDED MEDICAL QUESTIONS

The Santa Clara County Health Questionnaire contains 3 items that are open ended questions about medical problems experienced by the respondent. The responses are coded as exactly as possible by a physician, using the ICD-9 standard disease codes. When the response is vague, then ICD-9 codes for vague conditions are used. Although the limitations of respondent self-report of medical conditions must be borne in mind, the coding of the responses is in a structure accepted worldwide.

These coded responses are entered into the computer in the following way. The first ICD-9 code is split into an alpha character prefix and a 5 digit numeric code. The alpha prefix is recoded to a numeric value as indicated on the medical coding format sheet that follows, and entered into column 6. Then the numeric code follows. Because respondents may name the same medical condition in response to any or all of the 3 questions asked, the questions to which this particular medical condition relates is entered in column 12, using a multiple response coding scheme given on the format page that follows.

In a similar manner each of the ICD-9 codes are entered in sequence, for up to a maximum of 10 per respondent. This number was found to be adequate to handle the maximum number of responses.

Both Samples

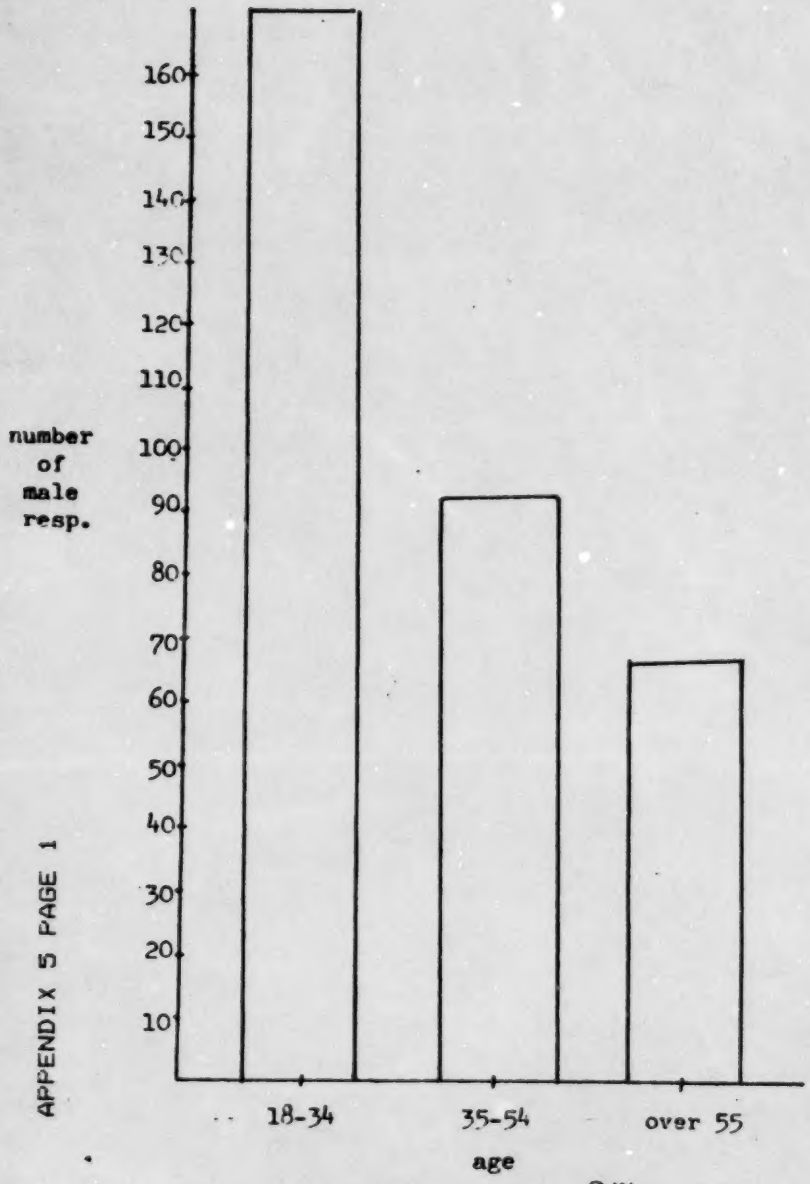
APPENDIX

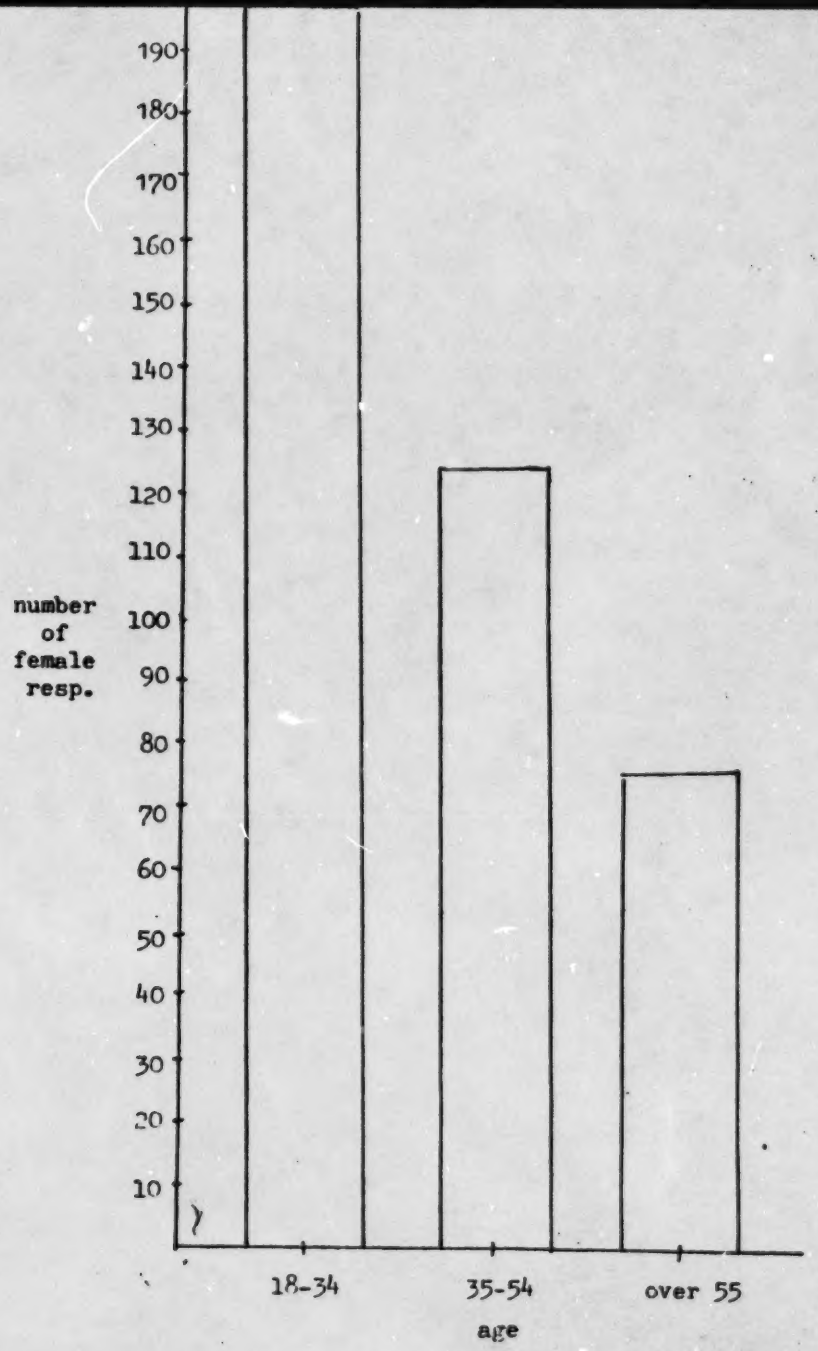
FORMAT FOR MEDICAL CODING

Col 1-4	ID No.	
Col 5	Card No.	
Col 6	Prefix	
	1 = E Code	
	2 = X or Procedure Code	
	3 = V Code	
	4 = Refused	
	5 = Pain, No Source	
Col 7-11	Code (2 decimals)	Answer 1.
Col 12	Question Code	
	1 = Question 1 only	
	2 = " 2 only	
	3 = " 3 only	
	4 = " 1 & 2	
	5 = " 2 & 3	
	6 = " 1 & 3	
	7 = " 1 & 2 & 3	
Col 13-19	Answer 2	
Col 20-26	" 3	
Col 27-33	" 4	
Col 34-40	" 5	
Col 41-47	" 6	
Col 48-54	" 7	
Col 55-61	" 8	
Col 62-68	" 9	
Col 69-75	" 10	

APPENDIX 5 PAGE 1

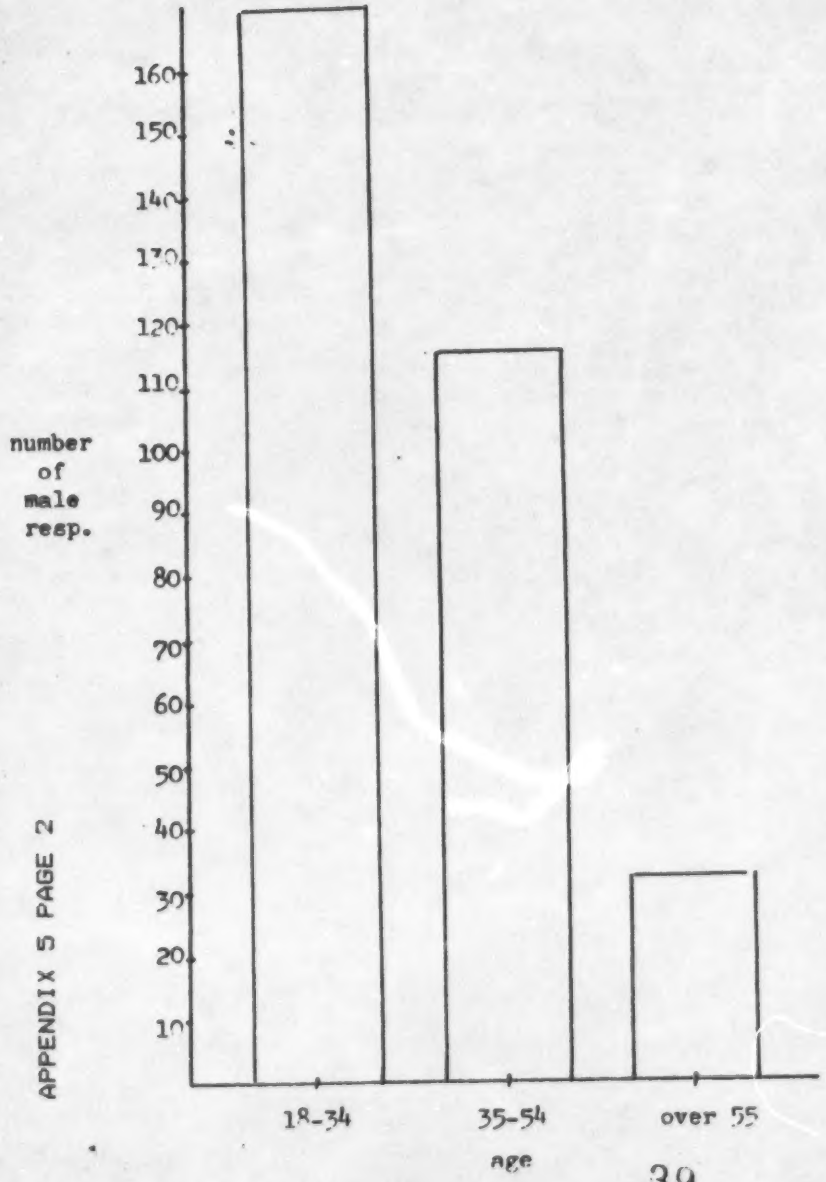
CHINESE RESPONDENTS
(Total)

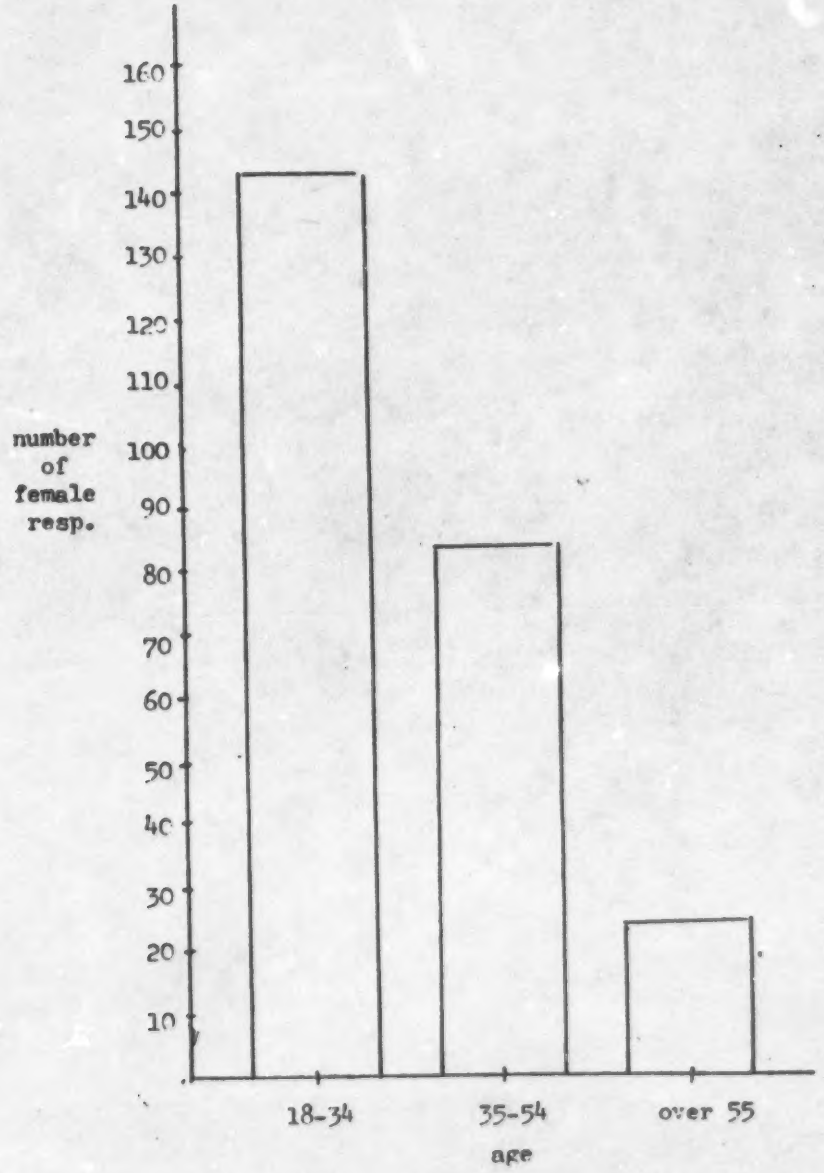




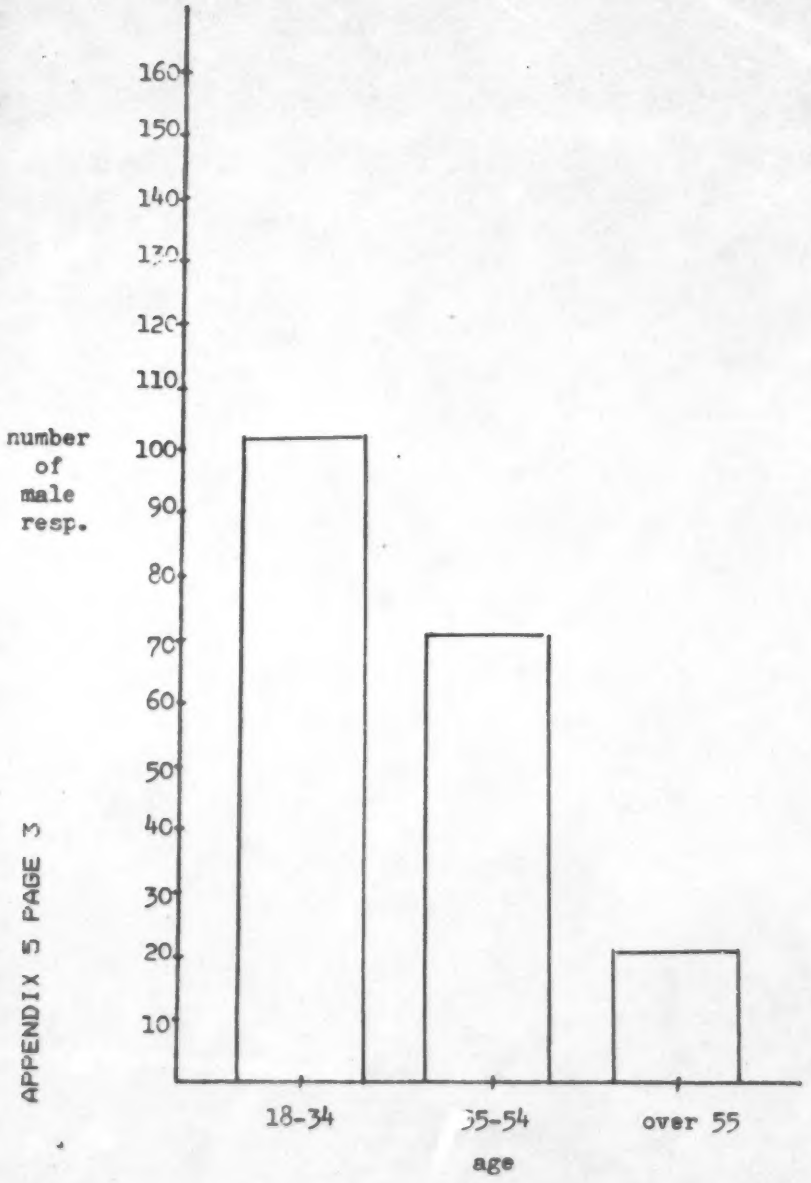
APPENDIX 5 PAGE 2

VIETNAMESE SPEAKING

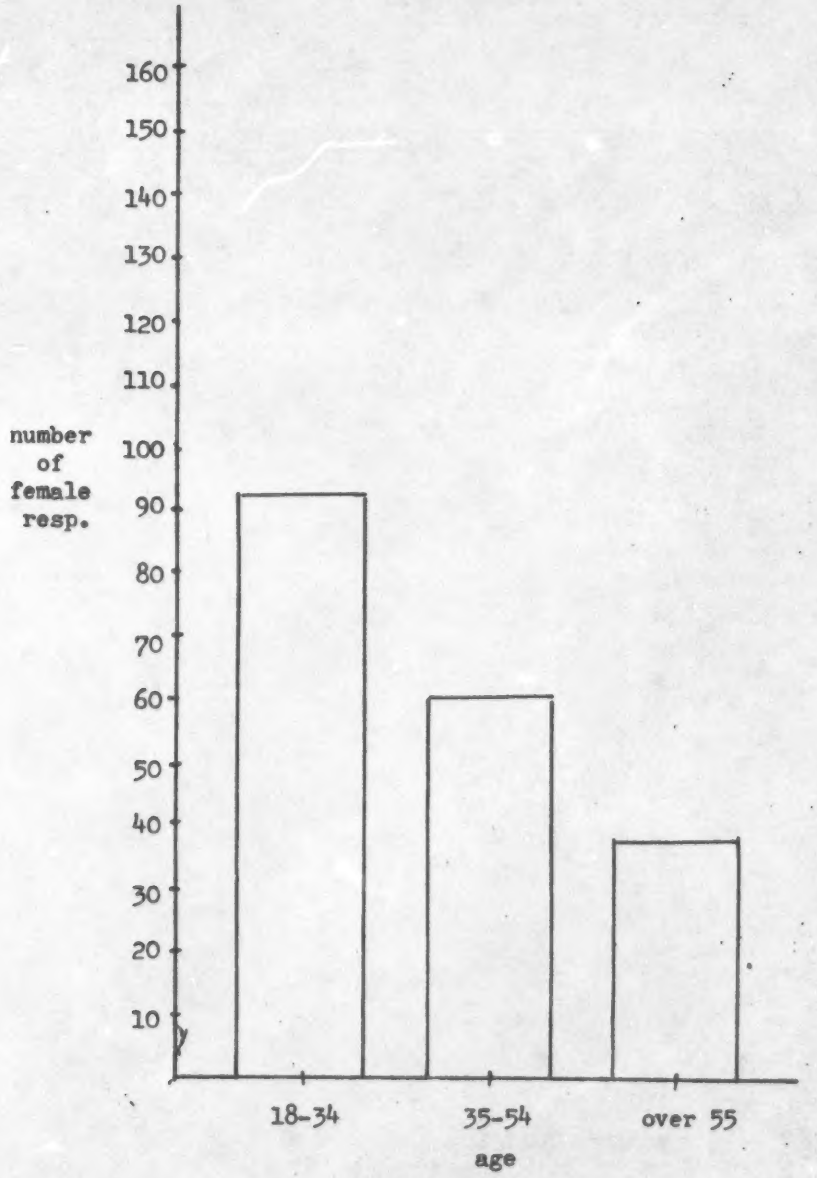




CAMBODIAN SPEAKING



APPENDIX 5 PAGE 3



RESUME

Kenneth Meinhardt, M.D.

Date of Birth: January 14, 1933 (Oklahoma City, Okla.)

Undergraduate Education:

University of Oklahoma, Norman, Oklahoma
Degree: B.S. (Chemistry), June 1954

Medical Education:

University of Oklahoma School of Medicine
Degree: M.D., June 1957

Internship:

Gorgas Hospital, Canal Zone, Panama
Rotating Internship July 1957 - June 1958

Psychiatric Training:

Metropolitan State Hospital, Norwalk, California
July 1958 - June 1961

Experience:

Agnews State Hospital After-Care Clinic
1961-66 - Staff Psychiatrist

Santa Clara County Central Mental Health Center
1966-68 - Supervising Psychiatrist

Santa Clara County Methadone Program
1970-71 - Member, Research Advisory Board
1971-72 - Acting Medical Director
1973-76 - Program Director

Santa Clara County Mental Health Administration
1968-73 - Chief of Clinical Services
1973-81 - Assistant Director of Mental Health
1981 to Present - Director of Mental Health

Santa Clara County Health Needs Survey: An epidemiologic community survey of a randomly chosen sample of county population, conducted by telephone interviews, 1980 - Project Director.

Fellow, American Psychiatric Association

Faculty Appointment: Stanford University, Clinical Lecturer - Psychiatry 1971 - present.

Solerg K. Tom, M. D.

Resume

1968	Stanford University A.B. Psychology, B.S. Biology
1969	Cedars-Sinai Hospital - Beverly Hills Research Assistant in Urology
1970	California State Health Department Chinese Hospital Epidemiological Study in Obstetrics and Gynecology
1971	Clinical Extern - Langley Porter Neuropsychiatric Institute San Francisco
1972	University of Arizona College of Medicine, M.D. degree
1973	Rotating Internship, Medicine/Psychiatry San Francisco
1973-76	Community Mental Health Psychiatric Residency San Mateo County
1976-present	Staff Psychiatrist Santa Clara County - Mental Health Bureau Palo Alto

ST/dw
08/33

Resume -- Connie Young Yu

Operations Manager -- Asian Health Survey Project
Santa Clara Health Department

Was a researcher and writer for the Chinatown Housing and Health Research Project in San Francisco from Fall 1978 - Dec. 1981. (funded by NIMH)

Consultant on Asian American studies, author of numerous papers and articles on Chinese American history and literature and Asian American perspective.

PHILIP C. TSE

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EDUCATION

San Jose State University, San Jose, CA
M.P.H.: Master of Public Health

California State University, Hayward, CA
B.S.: Biological Science

Loma Linda University, Riverside, CA
undeclared major

EXPERIENCE

Santa Clara County Health Department, Narvaez Mental Health Center, 614 Tully Road, San Jose, CA 95111

Rehabilitation Counselor - Working with a multi-disciplinary professional staff on cases involving adolescents, adults, elderly and families in direct and indirect services.
- Develop treatment and intervension strategies with cases who exhibited parent-child conflicts, marital conflicts, depression, adjustment disorder, sexual identity, psychosis and acute anxiety.
- Utilize various treatment approaches, from individual and supportive counseling, to conjoint family therapy, to problem solving crisis intervension.
- Education and prevention laison to area agencies and other county programs.

Santa Clara County Health Department, Downtown Mental Health Center, 1075 E. Santa Clara Street, San Jose, CA 95116

Nursing Attendant - Under direction, counael assigned clients on an individual and group basis and become familiar with individual needs.
- Know all appropriate referral and outreach agencies to conduct workshops and inservice training with professional staff members in case discussions.
- Provide mental health information and referral, community outreach.

TRAINING

Santa Clara County Health Department, Downtown Mental Health Center, 1075 E. Santa Clara Street, San Jose, CA 95116

Student Intern - Developed a resource file of literature and informational materials. Assisted in preparing materials to train high school students to be peer counselors and compiled data for reports.

PERSONAL DATA

Bi-lingual/Bi-cultural: Chinese and Vietnamese

Place of Birth: Saigon, Vietnam

Marital Status: Single

Health: Excellent